IDAHO DEPARTMENT OF
HEALTH & WELFARE

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June 1, 2010

FILE COPY

Michael Fenello
Complex Care Hospital Of Idaho
2131 South Bonito Way
Meridian, ID 83642

Provider #132002

Dear Mr. Fenello:

On **May 13, 2010**, a complaint survey was conducted at Complex Care Hospital Of Idaho. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004631

Allegation #1: A patient who was supposed to be resuscitated, was treated as a "Do Not Resuscitate" patient and subsequently died.

Findings #1: An unannounced visit was made to the hospital May 11 through May 13, 2010. During the complaint investigation, surveyors observed care, reviewed medical records (death records, closed records, open records) hospital policies, code review forms, staffing schedules, and administrative meeting minutes. They also interviewed patients, family members, and staff (i.e. registered nurses (RN), certified nursing assistants (CNA), physical therapists, physicians, case managers, a pharmacist, administrative staff, and agency contract staff). Surveyors also reviewed quality improvement data and incident reports.

Among the medical records reviewed was one record of a 66 year old woman who was admitted to the hospital on 2/04/10. The medical record indicated the patient was a "full code," meaning hospital staff should perform cardiopulmonary resuscitation (CPR) if needed. A Discharge Summary, dated 2/17/10, indicated a nurse went into the patient's room on the morning of 2/17/10 and found the patient

not breathing with no pulse. A Code Blue was not initiated and there were no attempts to revive the patient. During an interview on 5/12/10, with the RN who discovered the patient on the morning of 2/17/10, she stated she was aware the patient had been a full code. She explained she did not initiate CPR or a Code Blue (a term indicating pushing a button to alert an emergency response team) because family members (a sister and niece) were present in the patient's room; and the patient's sister directed her not to revive the patient. In order to honor the family's wishes, the RN did not initiate resuscitation measures or call a Code Blue. She stated that she later found out that the family members who were present in the room at the time of the patient's death did not have power of attorney. She realized she should have asked the family to leave the room and should have initiated a code.

The Director of Nursing and the Director of Quality Management both acknowledged the error and stated the nurse who failed to initiate the code received appropriate disciplinary action for not following the hospital's Code Blue policy. The nurse was also re-educated as to the appropriate way to respond.

The Director of Quality Management stated the incident had been reviewed and it was determined systems were in place that were sufficient to prevent similar incidents. She said this was an isolated incident and the nurse simply failed to follow the hospital procedure. She stated it was determined no further action was deemed necessary.

There were no similar incidents found among the death records reviewed. Because the hospital acknowledged the error and had assessed its procedures, a deficiency was not cited for the specific incident.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

Allegation #2: There was confusion among staff as to patient code status.

Findings #2: A hospital policy, Code Blue, revised 2/10, stated all patients would be considered "Full Code" status unless there were written physician orders that specified otherwise. The policy did not address if or how hospital staff were expected to verify code status, such as whether a physician's order was present for DNR/DNI (Do Not Resuscitate or Do Not Intubate). This lack of a clear policy may have contributed to confusion among staff and had the potential to result in inconsistent responses among staff.

On 5/11/10, the Director of Quality Management, Director of Nursing, and a hospitalist physician were interviewed together. They explained that patients' code

status was listed in medical records on the first page of nurses' notes and on the "blue sheet." Code status for each patient was also routinely reviewed during staff report at each change of shift. The Director of Quality Management and Director of Nursing explained the hospital had considered using bracelets on patients to identify code status but elected not to do so because of concern the practice was unsafe.

The Director of Quality Management was interviewed on 5/12/10 at 2:30 PM. In response to the question "How are staff supposed to verify code status?" she responded that she was not sure. She explained the hospital had not had to initiate Code Blues very often.

During individual interviews with 4 RNs between 5/11/10 and 5/13/10, there were inconsistent responses related to how to verify code status prior to initiating a Code Blue or beginning CPR. Two of the nurses indicated a need to find the medical record to verify code status prior to initiating a code (if they did not already know the code status). Delaying a code to look for patient records could interfere with patient safety and make a difference as to whether a patient lived or died. In contrast, two RNs stated they would initiate a code without trying to verify code status (if they did not already know the code status). This could interfere with patient rights to have advance directives honored and could be inconsistent with physician DNR/DNI orders.

It was determined, based on staff interview, policy review and record review, the hospital failed to establish a clear policy for staff to verify code status prior to initiating a code response. This lack of policy guidance led to inconsistent understandings among staff and had the potential to result in inconsistent responses from staff.

The hospital was cited at Title 42 Code of Federal Regulations Part 482.13(C2) for failure to ensure care in a safe setting.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #3: The hospital had inadequate nursing staff to meet patient needs, respond to call lights, maintain turning schedules. The nursing caseloads were too high. The hospital had a lack of sitters available to meet patient needs.

Findings #3: Ten RN's and five CNAs were individually interviewed between 5/11/10 and 5/13/10. Nine of the RNs and all of the CNAs stated they felt their caseloads were reasonable and they were able to attend to patient needs. The nurse who expressed some misgivings about the staffing levels was not able to offer specific examples

where care needs were not met due to inadequate staffing. Most of the nurses and CNAs acknowledged that staffing had been worse in the past but had improved over the past two months.

Five patients and four family members of patients were interviewed between 5/11/10 and 5/13/10. When asked about their perceptions/experience with nursing responsiveness to patient needs and answering call lights, all patients and the family members expressed satisfaction with nursing staffs' responsiveness to their call lights and needs. One patient stated her bed sores had decreased since arriving at the hospital. One family member stated her husband (the patient) arrived with a bedsore but it was no longer present since receiving care at the hospital.

The Chief of Staff, who was also the Rehabilitation Director, was interviewed on 5/12/10. He expressed satisfaction with nursing staffing levels and felt his patients were getting good nursing care. He stated there was a period of time when the hospital cut back on staff but found that wasn't working and re-added staff to the schedule. He stated he did not believe it was ever a patient safety issue but more a nurse satisfaction issue.

The physician who was the chief hospitalist, was interviewed on 5/13/10. She stated she participated as a member of the Medical Executive Committee and the Quality Improvement Committee. She stated she felt staffing levels were adequate to provide safe and effective care.

Five RNs were interviewed about sitters during the three day survey. All of the nurses stated the hospital had used sitters and sitters were available for use if needed.

The Director of Physical Therapy was interviewed on 5/12/10. She explained she participated in staff requests for sitters. Overall, she explained, the hospital discouraged use of sitters when less restrictive measures were available, such as including patients in activities with therapists and nurses or adding extra CNAs to the schedule to work more actively with patients.

It could not be determined the nursing caseload was excessive or that patient needs were not being met.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Nursing staff who were inexperienced in the Intensive Care Unit (ICU) were expected to work ICU.

Findings #4: During an interview on 5/11/10, the Nurse Educator stated nurses had to qualify to work in the ICU at their hospital, either by virtue of past experience or completion of a competencies checklist and supervised mentoring. She stated the hospital did not want nurses working in ICU without prior experience or without completing training in ICU.

Review of the hospital's staffing schedules indicated the hospital utilized agency nurses to help fill staffing needs. The Branch Manager from one of the staffing agencies (Medical Staffing Network (MSN) was interviewed by phone on 5/12/10. She stated that some of her nurses worked ICU doing observation of tele monitored patients. She denied the hospital utilized inexperienced agency staff in ICU. Further, she stated the only nurses who had been assigned ICU patients had been qualified to do so.

Twenty two RN personnel records were selected for review to verify experience and or training in ICU. These RNs were selected because they had been listed on the staffing schedule as having been assigned patients in ICU. Many personnel records showed ICU competencies or experience. Of the personnel records that did not clearly show competencies, the Director of Nursing was able to show how their backgrounds qualified them for their particular assignments. She stated she personally interviewed any agency nurses prior to allowing them to work at the hospital. She stated that credentials were verified. In order to allow a staff nurse or agency nurse to work in the ICU on the telemetry patients, they were required to be certified in Advanced Cardiac Life Support (ACLS). She denied being aware of any unqualified nurses being allowed to work in ICU. She stated it was possible that a house supervisor had mistakenly asked medical-surgical nursing staff to work the ICU, not knowing their full backgrounds. Nursing staff could and should decline any assignment they were not qualified to accept.

Of the 4 medical-surgical staff RNs that were interviewed between 5/11/10 and 5/13/10, all said they had on occasion accepted assignments in ICU of patients they felt qualified to care for, including telemetry patients or a high observation quadraplegic patient who could not use a call light. One nurse accepted a ventilator patient but stated she had experience with ventilators and felt comfortable accepting the patient with good back-up support. One RN stated she had been asked by two house supervisors at different times to work ICU accepting assignments she was not qualified to accept. She reported having declined the assignments.

It could not be determined that inexperienced, unqualified nursing staff were expected to work in ICU.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The hospital has excessive medication errors, particularly medications given late, as a result of limited pharmacy hours and lack of availability of pharmacy staff.

Findings #5: The Pharmacy Director was interviewed on 5/11/10 and again on 5/12/10. She explained the pharmacy was open 8:30 AM to 5:00 PM Monday through Friday and a pharmacist was on-call after hours. She also explained a Med Dispense was available to nursing staff after hours. The Med Dispense was stocked with medications that had been approved and were in the hospital formulary. Emergency medications were stocked in the Crash Cart. If medication was needed after hours, the house supervisor could access the medications by entering an over-ride in the system. If any medication was needed but not available, nursing staff was expected to contact the pharmacist on-call, who would come to the hospital or send needed stock. She stated she felt good about the available pharmacy staff and their ability to meet the needs of patients and nursing staff.

The pharmacist explained, in order to evaluate for any medication errors, her staff tracked all over-rides entered after hours in the Med-Dispense system. She explained the hospital had a culture of reporting any and all errors in their incident reporting system. The purpose of reporting was to track errors and initiate performance improvement measures to decrease errors. She stated the incident reports on medications were quite high the previous October and they had since significantly decreased.

Incident reports were reviewed from October 2009 through April 2010. A large number of incident reports involving medication errors were documented. Upon closer inspection however, most of these incidents were potential or technical errors that did not reach patients. Few actual errors had occurred. The Director of Pharmacy, interviewed on 5/13/10 at 9:25 AM, confirmed this. She stated staff were encouraged to report all potential errors and said those were analyzed in order to improve systems. She also confirmed the data showing medication errors had declined monthly for the past 3 months.

The Chief of Staff was interviewed on 5/12/10. He stated he participated in the Pharmacy and Therapeutics Committee. He explained the hospital made it a priority to limit errors and would prefer zero errors. The hospital had revamped education for agency nurses in order to reduce error rates. He stated he was aware some nurses were frustrated they had to go to the charge nurse/house supervisor after hours to access medications but described the practice as "good stewardship."

Nine RNs were individually interviewed. All of them stated they could access medications after pharmacy hours through the house supervisor. All reported pharmacy staff to be responsive to needs after after hours when contacted.

It could not be determined the medication errors were excessive or that pharmacy hours or lack of availability contributed the excessive errors.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: Patients have developed decubitus ulcers in the past 2 weeks.

Findings #6: The hospital routinely monitored the number of decubitus ulcers that developed at the hospital. Performance Improvement documents and interview with the Director of Quality Management showed no decubitus ulcers had developed at the hospital in 2010. A decubitus ulcer had developed at the hospital in December 2009. This had been healed. Five current patients had ulcers as of 5/11/10. These had all developed before the patients were admitted to the hospital. They were all being treated.

Medical records documented aggressive treatment of decubitus ulcers and other wounds. Skin checks were completed daily on all patients by a registered nurse. One patient had developed a reddened area on his buttocks in the past 2 weeks. This had been treated and no skin break down had occurred. The hospital had a wound care team consisting of a physician, nurse practitioners, registered nurses with specialized training, and a physical therapist. The entire team made rounds on all patients on a weekly basis. Wound care nurses were available 7 days a week. Wound care was documented 7 days a week.

The hospital had systems in place to identify and treat decubitus ulcers.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: The hospital had a large number of falls.

Findings #7: Incident reports were reviewed from October 2009 through April 2010. Incident reports showed a low number of falls. Only one fall with injury had occurred in the past 6 months. This was corroborated by interview with the Director of Quality Management.

The hospital had few falls.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #8: A patient was burned by a heating pad.

Findings #8: One medical record documented a patient with diagnoses including inflammation of the spinal cord with quadriplegia. A "NURSES NOTE" by the RN, dated 4/30/10 at 7:35 PM, stated "Pt had heating pads on his hands today because they were cold but refused to have towels between his hands and the heating pads. Pt has two blisters on his right hand."

An "INCIDENT REPORT," completed by the same RN at 11:30 PM on 4/30/10, stated a nurse's aide had placed the hot packs on the patient's hands and he had suffered 2 blisters. The incident report stated the patient refused to have a sheet or towel placed between the hot pack and his hands. The incident report stated the wound team would follow the burn and treat it as needed. The incident report stated nursing staff would be educated about sensation in patients with quadriplegia. The incident report did not state action had been taken to review the use of hot packs or modify their use to prevent further burns.

No other cases of burns were identified.

The Director of Quality Management and Director of Physical Therapy, who also managed the wound care team, were interviewed. Neither person knew what type of hot pack had been used or if they were still being used. A search of the hospital revealed "Accu-Therm Hot Packs" located on a supply cart. The packs consisted of a plastic bag with crystals and fluid in a separate bag. The surveyor broke the fluid bag and mixed it with the crystals. The bag immediately became hot. The temperature of the bag was measured at 115.6 degrees Farenheit. Until then the hot packs had been available for use by staff. The Director of Quality stated staff had not been trained in the use of the hot packs. The hot packs were removed from the supply cart at that time.

A deficiency was cited at Title 42 Code of Federal Regulations Part 482.21(C,2) for failure to take action to prevent further burns from the use of hot packs.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #9: Telemonitoring equipment did not work and staff did not watch the monitors.

Findings #9: The cardiac status of two patients was remotely monitored during the 3 day survey. Staff were watching either the monitor or the patient during observations on all 3

days. No incident reports were documented noting issues with the monitors.

The Director of Quality Management was interviewed. She stated there had been some difficulty getting the signal for telemonitors on the medical floor to carry to the intensive care unit where staff observed the monitors. The hospital currently moved medical patients who needed monitoring to the ICU to solve the problem. The Director of Quality Management stated the equipment had been upgraded and monitor technicians were being hired to allow medical patients to remain on the medical floor while their cardiac status was being monitored in the ICU.
During the survey, a telemonitored patient developed an arrythmia during the early morning hours of 5/12/10. Staff promptly recognized the arrythmia and notified the physician. The patient was treated.

No problems with telemonitoring were identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/sp

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FILE COPY

May 27, 2010

Michael Fenello
Complex Care Hospital of Idaho
2131 S Bonito Way
Meridian, ID 83642

RE: Complex Care Hospital of Idaho, provider #132002

Dear Mr. Fenello,

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on May 13, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction form, CMS-2567, listing Medicare deficiencies. The hospital is under no obligation to provide a plan of correction for Medicare deficiencies. If you do choose to submit a plan of correction, provide it in the spaces provided on the right side of each sheet. It is important that your Plan of Correction address each deficiency in the following manner:

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the POC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;

- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

Whether you choose to provide a plan of correction or not, please sign and date the form and return it to our office by **June 9, 2010.** Keep a copy for your records. For your information, the Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srp
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132002	A. BUILDING _____ B. WING _____	C 05/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLEX CARE HOSPITAL OF IDAHO	2131 SOUTH BONITO WAY MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey of your hospital. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Teresa Hamblin, RN, HFS Acronyms used in this report include: CNA = Certified Nursing Assistant Code or Code Blue = emergency response by staff to resuscitate a patient whose pulse or respirations had ceased DNR = Do Not Resuscitate DNR/DNI = Do Not Resuscitate, Do Not Intubate MD = medical doctor Pt = patient RN = registered nurse	A 000		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the hospital failed to establish a clear policy for staff to verify code status prior to initiating a "Code Blue" or begining CPR. This lack of policy guidance had the potential to result in inconsistent responses from staff. It could cause staff to delay calling a "Code Blue" or starting CPR when staff did not know a patient's code status and elected to find the code status in the medical record prior to initiating CPR. A delay in code response could make the difference between a patient living or dying. Also, lack of policy guidance could result	A 144	DEFICIENCY A144: To improve the process of verifying a patient's code status, and to provide clear direction on how staff is to proceed when an unresponsive patient's code status is in question, Complex Care Hospital of Idaho (CCHI) will: Add code status of all patients to the Shift Change Report o Clinical Education Report each patient's code status during Shift to Shift Report at the beginning of each shift o Director of Nursing o Nurse Supervisors Report each patient's code status as well as any change in the code status to the Nursing Supervisor and the Code Response Team members o Director of Nursing o Nurse Supervisors	5/13/2010 6/7/2010 6/7/2010

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JUN - 8 2010
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael A. Jendell | TITLE: CEO | (X6) DATE: 6-7-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 144	Continued From page 1 in staff immediately initiating CPR in patients who turned out to have physician orders for DNR. This would violate patient rights to have advance directives honored and result in a failure to follow physician DNR orders. Findings include: A hospital policy, "Code Blue," revised 2/10, stated all patients would be considered a "Full Code" unless written physician orders specified otherwise. The policy did not address if or how hospital staff were expected to verify code status, such as whether a physician's order was present for DNR/DNI. On 5/11/10 at 2:15 PM, the Director of Quality Management, Director of Nursing, and a hospitalist MD were interviewed together. They explained patient code status was listed in medical records on the first page of nurses' notes and on a physicians' order form for resuscitation status. Code status was also reviewed during staff report regarding patients at each change of shift. The Director of Quality Management and Director of Nursing explained the hospital had considered using bracelets on patients to identify code status and had elected not to do so because they considered bracelets as "not safe." During an interview on 5/12/10 at 2:30 PM, the Director of Quality Management explained the reason bracelets were considered "unsafe." She stated different hospitals used different colors to represent code status. Many of their staff had worked at other hospitals. Using colors, she explained, could confuse staff, especially agency staff who worked at different hospitals, potentially resulting in an inappropriate response to a code. When asked the expected procedure to verify code status, she stated she was not sure. She	A 144	Provide edueation to all hospital staff including PRN staff and agency/contraet staff. Education consisted of ✓ Education to policy #001-48-036.5 - Code Resuscitation Status which states, "Any patient without a designated Code Status will receive Full Code (Full Resuscitation) therapies. The Code Status shall be communicated to the patient care team." ✓ The expected process at CCHI for when a staff member finds an unresponsive patient and the code status is not verified, is: ☐ Staff will initiate the emergeney button to alert the Nursing Supervisor and Code Response Team of the emergeney, assess the patient's airway, breathing, and circulation while awaiting the the Response Team ☐ The Response Team will respond with the crash cart, verify the patient's code status, upon arrival and respond appropriately. Code Blue drills and the Code Blue outcomes have verified arrival time to be less than one minute. ✓ Kardex Education to nursing staff ineludes ☐ Documenting code status on Kardex ☐ Keep Kardex in soft chart at patient's room ☐ Update Kardex appropriately o Director of Nursing o Clinical Education Include the process for initiating response for a patient with unverified code status to New Employee Orientation, and to Self Paced Orientation manual for orientation and education of agency and contracted services staff o Clinical Edueation	Education began 5/13/2010. All staff including PRN, agency, and contracted services staff will have doeumented education no later than 6/30/2010 Completed 6/7/2010

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A 144	Continued From page 2 stated the hospital had not had to initiate many Code Blues. During an interview on 5/12/10 between 10:00 - 10:30 AM, RN 1 described an incident in February 2010. She stated an agency CNA called her into the room of a patient whose blood sugar had declined and who was not responsive. RN 1 had not been assigned the patient and was unfamiliar with the patient's code status. The patient's medical record could not be found at the nurses' station. Later, RN 1 discovered the medical record had been in the medication room with another nurse. She described having pressed the Code Blue button in the patient's room to get some help. Help arrived and the patient recovered. She stated she knew the code status of her own patients but did not know the code status of the patients assigned to other nurses. This became an issue, she explained, when she had to cover for other nurses at lunch time or when she was called into a room belonging to a patient not already assigned to her care. She stated she thought it would be helpful to have some indication of patient code status closer to patients or their rooms. During an interview on 5/13/10 at 1:30 PM, RN 2 described an incident when she had been called to the room of a patient with whom she was not familiar. She did not know the patient's code status and sent a CNA to look it up in the patient's medical record. She stated it could have been a problem if the record had not been found quickly. She stated she thought it would be a lot easier if patients wore a bracelet to identify code status. During an interview on 5/13/10 at 7:20 AM, RN 3 stated she would initiate a code immediately if a	A 144	Measurement of effectiveness will occur through • Code Blue drills conducted by Clinical Education and the Patient Safety Committee will include involvement of staff not assigned to the "Drill Patient". o Director of Quality Management o Clinical Education • Random nursing staff interviews regarding knowledge of patient code status, as well as knowledge of process when code status is unknown. o Director of Nursing o Nursing Supervisors o Director of Quality Management • Results of the drills and staff interviews will tracked for one year and reported to the Quality Committee, Patient Safety Committee, Safety Council, MEC and Governing Board by the Director of Quality Management o Director of Quality Management	Ongoing Ongoing Ongoing

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A 144	Continued From page 3 patient stopped breathing. She would not take the time to find the chart to verify code status. She stated she would later stop the code if she found out the patient had a DNR order. Similarly, during an interview on 5/12/10 at 7:45 AM, RN 4 stated if a patient stopped breathing, she would initiate a code and continue until someone told her the patient had DNR orders. During an interview on 5/12/10 at 2:00 PM, RN 5 stated she did not know if Patient #4, who was assigned to her that day, had DNR orders or not. She went to the nursing station and looked at his medical record before giving the surveyor a definitive answer. The hospital failed to give clear direction on how to verify code status and respond quickly and accurately to patient conditions requiring a code response.	A 144		
A 288	482.21(c)(2) QAPI FEEDBACK AND LEARNING [Performance improvement activities must track medical errors and adverse patient events, analyze their causes and] implement preventive actions and mechanisms that include feedback and learning throughout the hospital. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and quality improvement documents, it was determined the hospital failed to ensure preventative actions were taken to protect patients from burns. This directly impacted 1 of 1 patient (#11) who suffered burns from a chemical heating pad. This had the potential to place other patients at risk of burns. Findings include: Patient #11's medical record documented a 23	A 288	DEFICIENCY A288: To prevent placing patients at potential risk for burns, CCHI: Located and removed Accu-Therm Hot Packs from Supply Rooms on ICU and Med/Surg Units. o Director of Physical Medicine and Rehabilitation Services Removed Accu-Therm Hot Packs from Hospital Inventory List o Director of Physical Medicine and Rehabilitation Services o Materials Manager To prevent the purchase of materials not approved for use at CCHI the following process was implemented. ✓ All requests for supplies/equipment not listed on the Hospital Inventory List must be approved by the Materials Manager and the appropriate Department Director(s) o Materials Manager o Department Director(s) To monitor compliance with the above process, the following indicator was added to the Materials Department Indicators for 2010: *# of requests for purchase of supplies/equipment not on approved Hospital Inventory List, and not approved by the appropriate Department Director(s)* o Materials Manager	Completed 5/13/2010 Completed 5/13/2010 Completed 5/13/2010 Completed 6/3/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132002	A. BUILDING _____ B. WING _____	C 05/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLEX CARE HOSPITAL OF IDAHO	2131 SOUTH BONITO WAY MERIDIAN, ID 83642

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A 288	Continued From page 4 year old male who was admitted to the hospital on 4/07/10 and was discharged on 5/11/10. His diagnoses included inflammation of the spinal cord with quadriplegia. A "NURSES NOTE" by the RN, dated 4/30/10 at 7:35 PM, stated "Pt had heating pads on his hands today because they were cold but refused to have towels between his hands and the heating pads. Pt has two blisters on his right hand." An "INCIDENT REPORT," completed by the same RN at 11:30 PM on 4/30/10, stated a nurse's aide had placed the hot packs on Patient #11's hands and he had suffered 2 blisters. The incident report stated Patient #11 refused to have a sheet or towel placed between the hot pack and his hands. The incident report stated "Pad removed. Wound team following [with] treatment as needed." Under the heading "Actions Implemented," the report stated "Physical Therapy to work [with] nursing to provide education to nursing about [quadriplegia] care re: sensations." The Director of Quality Management was interviewed on 5/13/10 at 10:15 AM. She stated she did not know what type of hot pack was used or where the aide had obtained the hot pack. The Director of Physical Therapy, who was also the manager of the wound care team, joined the interview with the Director of Quality Management. The Director of Physical Therapy also stated she did not know what type of hot pack had been used. She stated the physical therapy department had decided not to use hot packs because of the possibility of burns. Then she went to the clean central supply on the medical floor to investigate. She returned at 11:00 AM with several "Accu-Therm Hot Packs."	A 288	To monitor compliance to the process, the number of requests for supply/equipment purchases not on the Hospital Inventory List and not approved by the appropriate Department Director(s) will be reported to the Quality Committee, the Safety Council, MEC, and Governing Board as part of the Materials Management Department Indicators. o Director of Quality Management To assure patients receive safe care at CCHI, staff will receive documented education on the proper and safe use of supplies and equipment o Materials Manager o Department Director o Clinical Education Incidents with adverse patient outcomes will continue to be investigated thoroughly by Quality Management and the appropriate Department Manager(s). Documentation of findings will include steps taken to prevent incident from happening again, as well as education provided to staff to prevent a repeat of the incident. The Ineidents and the recommendations to prevent the incident for happening again will be reported at the Quality Committee, Patient Safety Committee, Safety Council, MEC, and Governing Board. o Director of Quality Management Monitor and track for one year the number of serious incidents with appropriate follow-up reports to Quality Committee, Patient Safety Committee, Safety Council, MEC, and Governing Board to demonstrate compliance. o Director of Quality Management	Ongoing Ongoing Ongoing Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132002	A. BUILDING _____ B. WING _____	C 05/13/2010

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A 288	Continued From page 5 She stated she had just removed them from the supply cart. The packs consisted of a plastic bag with crystals and fluid in a separate bag. The surveyor broke the fluid bag and mixed it with the crystals. The bag immediately became hot. The temperature of the bag was measured at 115.6 degrees Farenheit. Until then the hot packs had been available for use by staff. The Director of Quality stated staff had not been trained in the use of the hot packs. The hot packs were removed from the supply cart at that time. The hospital failed to remove the hot packs after Patient #11 was burned and failed to educate staff in their safe use.	A 288		